TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Methodist Willowbrook

Respondent Name
TX Public School SC Project

MFDR Tracking Number
M4-16-2961-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting a Medical Dispute because insurance carrier is denying the claim for missing or invalid authorization. I submitted a detailed letter with my reconsideration that explains why I think the authorization is valid and the bill was still denied..."

Amount in Dispute: $18,754.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the preauthorization letters in this claim support the determination that the services billed by Requestor, including implants and OR services, do not match the procedures for which preauthorization was sought and obtained by Requestor from IMO, Respondent's utilization review agent."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10 – 13, 2015	Inpatient Hospital Services	$18,754.46	$18,754.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

3. 28 Texas Administrative Code §134.600 sets out the guidelines for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 146 – Diagnosis was invalid for the date(s) of service reported
   - 150 – Payer deems the information submitted does not support this level of service
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - Notes – Medical records needed to support this date of service
   - 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider
   - 18 – Exact duplicate claim/service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking a payment of $18.754.46 for outpatient hospital services rendered on November 10, 2015. The carrier states "…implants and OR services, do not match the procedures for which preauthorization was sought and obtained by Requestor." The explanation of benefits included such denials as 15 – "The authorization number is missing, invalid, or does not apply to the billed services or provider."

   28 Texas Administrative Code §134.600 (p) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > > (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
   > >
   > > (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the submitted documentation finds:

   - Preauthorization Determination Letter Amended 11/6/2015
     - ICD-10 M17.12 – Unilateral primary osteoarthritis, left knee
     - Authorization # 82208
     - Date of service – 10/22/15 to 12/30/15
     - Determination note: IMO has preauthorized medical necessity for Total Left Knee Replacement with 3 day inpatient stay to be done on an inpatient basis
     - ODG Indications for Surgery – Knee arthroplasty
     - Operative Report from 11/10/2015 – Preoperative Diagnosis: 2. Left knee severe tricompartmental knee osteoarthritis
     - Procedures: Left total knee arthroplasty
     - Medical claim box 63, treatment authorization codes, 82208
     - Medical claim box 66, DX - M17.12
     - Medical claim box 74 , principal procedure code, "OSRD0J9" – Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach

Based on the evidence found during this review, the Division concludes the services performed by the health care provider for the date November 10 – 13, 2015 were authorized and are payable. The applicable reimbursement guidelines are discussed below.

2. 28 Texas Administrative Code §134.404(f)(1) establishes the fee guideline as follows,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
> >
> > > (A) 200 percent; unless
> > >
> > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

3. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates are found at http://www.cms.gov.

   Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 470. The services were provided at Methodist Willowbrook Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $13,138.58. This amount multiplied by 143% results in a MAR of $18,788.17.

4. Per the applicable fee guideline, the total payment for the services in dispute is $18,788.17. The insurance carrier has paid $0.00. The requestor is seeking $18,754.46. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $18,754.46.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $18,754.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.